STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155654	A. BUILDING 01 B. WING	12/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE RD FORT WAYNE, IN46809

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/01/11 Facility Number: 000498 Provider Number: 155654 AIM Number: 100266110 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Englewood Health & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111)	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor. The facility has a capacity of 67 and had a census of 59 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/02/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 2 resident records storage rooms with combustibles, measuring over	K0029	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan	12/30/2011

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	50 square feet in size, were provided with a self closing device. This deficient practice could affect any resident near the Business office. Findings include: Based on observation with the Maintenance Director on 12/01/11 at 12:00 p.m., both corridor doors to the Business office with combustible storage, measuring over 50 square feet in size, lacked a self closing device. The Business office contained six cardboard boxes of resident records and other documentation. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the corridor door to 3 of 3 shower rooms used for storage of soiled linen, therefore creating a hazardous area, were provided with a door that would self close and latch into the frame. This deficient practice could affect all		of Correction is submitted to meet requirements established by state and federal law. 1. The facility has removed all alleged boxes that are not stored from the business office. The facility added a self closing device to all three alleged shower room doors. 2. The alleged deficiency had the potential to affect all residents. 3. Maintenance Supervisor will audit to ensure that the shower room doors are self closing properly and the business office is free from unstored boxes. 4. Maintenace Supervisor will check the business office and shower rooms weekly x4 then monthly thereafter until compliance is achieved. Results will be forwarded monthly to the QA Committee Meeting. 5. To be completed by 12/30/11.	

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	residents. Findings include: Based on observation with the Maintenance Director on 12/01/11 from 12:14 p.m. to 12:35 p.m., soiled linen barrels were stored in the shower rooms on the 100, 200 and 300 halls. These shower rooms' corridor doors lacked latching hardware and did not latch into the door frame. Based on an interview with the Maintenance Director at the time of observation, soiled linens are stored in these barrels until they are taken by the laundry staff to the laundry room. 3.1-19(b)			
K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review and interview, the facility failed to ensure 1 of 8 emergency light fixtures of at least 1½ hour duration was tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of	K0046	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	12/30/2011

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	Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on review of the "Battery-Operated Emergency Lights" log with the Maintenance Director on 12/01/11 at 11:08 a.m., there was no documentation of an annual test on the battery operated emergency task light at the generator. This was acknowledged by the Maintenance Director at the time of record review. 3.1-19(b)		requirements established by state and federal law. 1. Maintenance Supervisor will complete an annual test for the alleged emergency light at the generator. 2. The alleged deficiency had the potential to affect all residents. 3. The facility will test all battery operated emergency lighting: Monthly Test will be a 30 sec. test and the Annual Test will be for 90 min. All tests will be record on the TELS Electronic Record. 4. The facility has an electronic audit tool for the Maintenance Supervisor to do the monthly checks. Results will be forwarded monthly to QA Committee Meeting. 5. To be completed by 12/30/11.	

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K0048 SS=C	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written fire plan that included the use of all fire extinguishers including the kitchen fire extinguishers for the protection of 59 of 59 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect any number of occupants in the event of an emergency. Findings include: Based on record review with the	K0048	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. The facility will update the alleged current fire plan to include all necessary information. 2. The alleged deficiency had the potential to affect all residents. 3. Maintenance Supervisor will inservice all staff on the updated fire plan. Facility will include an updated fire plan located at each nurses station. 4. The updated fire plan will be reviewed, updated and inserviced annually. 5. To be completed by 12/30/11.	12/30/2011

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	Maintenance Director on 12/01/11 at 11:52 a.m., the "Fire Policy and Procedure" documentation did not address the use of the fire extinguishers including the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review. 3.1-19(b)			
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for	K0069	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. The facility placed a placard conspicuously near the class K extinguisher in the kitchen area. 2. The alleged deficiency had the potential to affect the 32 residents on 100 & 200 Hall. 3. Maintenance Supervisor will inservice Dietary Staff on the fire	12/30/2011

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	Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen. Findings include: Based on observation with the Maintenance Director on 12/01/11 at 1:11 p.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview with the Maintenance Director at the time of observation, the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic		protection system, including the class K extinguisher. Maintenance Supervisor will review monthly to ensure the placard is still in place. All reviews will be recorded on the TELS electronic record. 4. The facility has an electronic audit tool for the Maintenance Supervisor to do the monthly checks. Results will be forwarded monthly to QA Committee Meeting. 5. To be completed by 12/30/11.	

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	fire suppression system. 3.1-19(b)			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 15 resident room corridor doors on the 300 hall closed and latched into the door frame. This deficient practice could affect any of the 27 residents on the 300 hall. Findings include: Based on observation with the Maintenance Director on 12/01/11 at 12:59 p.m., the corridor door to resident room 315 failed to latch into the door	K0018	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. The alleged deficient door to room 315 has been realigned and fixed to latch properly. 2. The alleged deficiency had the potential to affect the 27 residents on the 300 Hall. 3. Maintenance Supervisor will check all resident room corridor doors monthly. All tests will be recorded in an electronic audit	12/30/2011

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	frame. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		tool. 4. The facility will create an electronic audit tool to check and monitor for compliance monthly. Results will be forwarded monthly to the QA Committee Meeting. 5. To be completed by 12/30/11.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of	K0144	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. The facility will obtain an official company letter from an off site fuel source. 2. The alleged deficiency had the potential to affect all residents. 3. Maintenance Supervisor to be inserviced on the importance and need to have an emergency off site fuel source in place and review annually. 4. Maintenance Supervisor will review and update an off site emergency fuel source annually. 5. To be completed by 12/30/11.	12/30/2011

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	off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas			

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	provider. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director on 12/01/11 at 11:00 a.m., the only letter regarding the natural gas fuel source for the emergency generator was from TLC Management and not the natural gas provider. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review. 3.1-19(b)			
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and	K0147	The following Plan of Correction	12/30/2011

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	interview, the facility failed to ensure 6 of 11 of the 300 hall resident rest rooms, a wet location, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as areas subjected to wet conditions. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 17 residents on the 300 hall in the event of an electrical short. Findings include: Based on an observations with the Maintenance Director on 12/01/11 from 12:48 p.m. to 12:59 p.m., the individual restrooms for resident room 301,		constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. The facility to make sure all alleged outlets are provided with GFCI Protection. 2. The alleged deficiency had the potential to affect the 27 residents on 300 Hall. 3. Maintenance Supervisor will review all resident room outlets to ensure GFCI Protection. Maintenance Supervisor will test the GFCI Outlets monthly. 4. The facility will create an electronic audit tool to check and monitor for compliance monthly. Maintenance Supervisor will test all resident room outlets monthly x2 then quarterly thereafter until compliance in achieved. Results will be forwarded to monthly QA Committee Meeting. 5. To be completed by 12/30/11.	

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	302 and the shared restrooms for resident room 304/306, 305/307, 308/310 and 309/311 had an electrical receptacle on the wall located twenty six inches from the hand sink. When the receptacles were tested with a GFCI testing device provided by the facility, and the button was pressed by the Maintenance Director, power was not interrupted. Based on an interview with the Maintenance Supervisor at the time of observation, these receptacles were not provided with GFCI protection. 3.1-19(b)			